Family Practice — World Perspective

Recent Changes In General Practice In The United Kingdom

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In November 1987 the United Kingdom Government published its white paper *Promoting Better Health*,[1] which described its program for improving primary health care services. This paper followed extensive consultations on two previous documents: *Primary Health Care: An Agenda for Discussion*[2] and *Neighbourhood Nursing — A Focus for Care*.[3] Not since 1965 had there been such a comprehensive review of general practice in the United Kingdom, and this 1987 publication led to important changes in the way general practitioners practice. The changes were so extensive that new contractual arrangements had to be made; the New Contract took effect in April 1990.[4]

Primary Health Care: An Agenda for Discussion

In its original discussion document[2] the UK Government set out its objectives:

1. To make services more responsive to the needs of the consumer
2. To raise standards of care
3. To promote health and prevent illness
4. To give patients the widest range of choice in obtaining high-quality primary care services
5. To improve value for money
6. To enable clearer priorities to be set for the Family Practitioner Services (general practice and community dental, pharmaceutical, and ophthalmic services) in relation to the rest of the health service

To achieve its aim of requiring general practitioners to increase the range and quality of services they provided, the UK Government described three essential elements: to increase competition amongst those providing Family Practitioner Services, to provide consumers of care with more information about available services, and to develop a performance-related contract.

New Contract

The main changes in the New Contract[4] were as follows:

1. Publication by employing authorities of local directories of family doctors
2. Simplification of the arrangements for changing doctors
3. Publication by general practitioners of leaflets detailing the services provided by the practice
4. Development of consumer satisfaction surveys
5. Revision of the "complaints" procedures
6. Inclusion of health promotion and disease prevention reinforced by "target" payments for achievement
7. Tighter control over the minimum availability of general practitioners holding National Health Service contracts
8. Requirements for training and appropriate qualification of professional health care staff including practice nurses
9. Preparation of an annual report by each practice including information about staffing and accommodation, prescribing arrangements, and hospital referral statistics

At the same time payment arrangements were altered to place more emphasis on capitation and thereby to reward general practitioners who attracted new patients by providing comprehensive, high-quality service. Consequently less emphasis was placed on item-of-service payments: for example, individual payments for immunization procedures and the taking of cervical smears were replaced by defined percentage cover target payments. These payments had the effect of

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raising the number of patients immunized and the number of cervical smears taken by general practitioners.

The average net remuneration of general practitioners working in the National Health Service is set annually by the UK Government acting on advice from the Doctors' and Dentists' Review Body. As of 1 April 1994 this figure is slightly more than US $60,000. Most general practitioners have additional outside income (e.g., private practice, occupational health appointments, and medicolegal and insurance reports) of about US $6,000. A full-time National Health Service hospital consultant will be paid US $58,000 to $75,000.

Working for Patients

In addition to these contractual changes, general practitioners had to cope with a second white paper, *Working for Patients*.[5] In the late 1980s, faced with changes in demography, rapid developments in medical technology, and changing patient expectations, the then prime minister, Margaret Thatcher, instituted a wide-ranging review of the National Health Service. It had been recognized some years previously that as the largest employer in Europe the National Health Service had to strengthen its management arrangements. *Working for Patients* proposed a separation of the "purchaser" function of health authorities and general practitioners from the "provider" aspect of health care. Hospitals and community units were encouraged to become self-governing trusts and sell the services they offered to health authorities and to some groups of general practitioners, who would thereby purchase a range of services appropriate to the needs of their patients. It was the stated intention of the UK Government that the principles on which the National Health Service had developed since 1948 would continue, i.e., universal availability, free at the point of delivery, and financed mainly out of general taxation. The effect of these changes was to decentralize much of the administration, giving local health care staff more responsibility for responding to local needs. To ensure optimal use of resources, all physicians had to participate in medical audit, and the arrangements for controlling expenditure were strengthened.

One main aim of the changes was to strengthen primary care by giving selected general practices substantial sums to purchase hospital services, thereby enabling money to follow the patient. The advocacy role of the general practitioner, exemplified by the registered list system and the gatekeeper function, would be critical in ensuring that hospital services would reflect local needs.

Initially fund-holding was intended to be restricted to practices of at least 10,500 patients, but before the scheme started, the number of patients was reduced to 9,000 (now 7,000). Small practices are able to combine their lists, and a few practices with even smaller list sizes are now taking part with careful evaluation. A number of large consortia have been formed with consequent reductions in management overheads. The ideal size has not yet been established.

General Practice Fund-holding

Before the creation of practice budgets general practitioners had little control (or even interest) in the organization or delivery of secondary care services. In April 1991 selected general practices were given budgets to purchase directly health care from three different areas.

About 60 percent of the budget is allocated to some hospital services: (1) outpatient services (with the exception of radiotherapy and oncology), (2) a fairly wide range of nonemergency hospital inpatient care, and (3) diagnostic tests, e.g., radiographs and pathology requests. Approximately 30 percent is allocated to prescribing (including dispensing costs), and the remainder is available to reimburse a proportion of staff costs.

In April 1993 the scope of fund-holding was extended to include most district nursing and health visiting services, referral for chiropody services and dietetic advice, and all outpatient mental health services.

Because of poor information systems and the absence of a previous model, much of the preparatory year for fund-holding — the preferred term for practice budget holding — was devoted to describing historical referral and treatment patterns, upgrading computing systems to cope with the extensive paperwork and accounting procedures, reconciling the accounting systems, training staff to operate the new system, negotiating an agreed budget, and arranging contracts with provider units. The provider units could range from National Health Service Hospitals or Trusts and private hospitals to other general

practitioners who possessed particular areas of expertise, e.g., in outpatient surgical techniques. An average practice of 10,000 patients has a fund of about US $2 million. In the first year of the scheme less than 10 percent of all patients were covered by fund-holding practices, but by April 1994, when the fourth wave of practices started to run their own funds, more than 30 percent of the population belonged to fund-holding practices.[6]

Some Consequences of Change

It is almost 4 years since the New Contract was imposed upon general practitioners and 3 years since the National Health Service and Community Care Act of 1990 enabled general practice fund-holding to start. What has happened to general practices and general practitioners during the intervening period?

It is not easy to separate the effects of these two different developments. Some of the changes resulting from the New Contract — particularly the emphasis on some health promotion activities of doubtful value, e.g., three yearly checks of adults[7] or annual examinations of patients older than 75 years, together with the marked increase in paperwork — have caused many general practitioners to feel unduly stressed.[8] This situation has been exacerbated by tighter management of the general practitioner's contract, which to some extent has been counterbalanced by a perception by many fund-holders of greater control over what happens to their patients.

Although the Department of Health in England failed to carry out any pilot projects, others have evaluated the results of general practice fund-holding. Some reports have already been published. One of the earliest was by Glennerster, et al.[9] whose study reported on the first preparatory year of funding in 10 practices. Their findings confirmed that general practice fund-holding replaced the top-down model of resource allocation with a bottom-up system driven by general practitioners, resulting in the consequent shift in the balance of power from hospital specialists and administrators to the general practitioners acting on behalf of their patients.

In Scotland the Health Department commissioned Professor John Howie to conduct an independent examination of the scheme in a number of practices in that country. Although it might take 10 years to evaluate the effects, the first results were published early in 1993.[10] Howie and colleagues described three areas of success and three areas of difficulty.

On the success side they found that the practices examined, contrary to the national trend, had developed a positive approach to change and innovation, had become more cost and management conscious, and by the incorporation of quality standards in their provider contracts, had the potential to raise the quality of care. This last factor was also noted by Bain.[11] Many of these quality issues, e.g., shorter waiting times and improved communications between the hospital and general practice, have benefited all patients regardless of whether they belong to a fund-holding practice.

On the other hand, Howie, et al. noted that at least in the early stages information systems and the necessary developments in computing were seriously lacking. They also thought that the process of allocating budgets was too subjective and believed that this subjectivity would give rise to problems in the future. They had concerns also about the purchasing decisions of general practitioners and whether they might conflict with patients' best interests.

It is in relation to their second concern that the British Medical Association has expressed most forcibly its greatest objection. It believes that the development of two types of general practices has led to a two-tier service whereby the patients of nonfund-holding practices, whose hospital care is funded in the traditional way by means of a block contract between the Health Authority as purchaser of care and the hospital as a provider, have a lesser degree of priority than those of fund-holders. There is some indication of this reduced priority.[12] On the other hand, many general practitioners have elected to become fund-holders because of the inequities that are inevitably created by the mixture of National Health Service and the private practice in which many hospital specialists currently engage and by a long-standing uneven geographical distribution of resources.

Although some of the changes in the New Contract meant that all general practitioners had to improve their management skills, the requirement placed on fund-holders to prepare a business plan specifying areas of development to be funded either from the agreed fund or from savings has been one of the most important

achievements of fund-holding. Any savings a practice makes in its annual budget can be spent on the development of services for the benefit of the practice and can be retained for that purpose for up to 4 years.

Insofar as the third area of difficulty is concerned, studies by Coulter and Bradlow[13] have shown, for example, that there is no evidence that fund-holders have changed their referral patterns in any meaningful way. With respect to prescribing activities — that part of the fund in which the greatest savings potentially can be made and where detailed information has been available to all general practitioners for many years — Bradlow and Coulter[14] have reported that fund-holders were more effective than nonfund-holders in curbing prescription costs despite both groups increasing both the number of items prescribed and the average cost per item. This cost curbing was achieved partly by a greater use of generic drugs and also by the development of practice formularies leading to greater consistency in prescribing.

General practitioners themselves report, however, that there has been a considerable increase in time devoted to administration after the New Contract was imposed. The Department of Health is currently negotiating with the General Medical Services Committee of the British Medical Association about ways of reducing the burden of administration and continuously increasing patient demand.

Fry[15] reported the results of two surveys of physicians' time carried out in 1985–86 and 1989–90. The latter survey showed that general practitioners spent slightly more than 60 hours per week on general medical services — 44 percent for office consultations, 24 percent on home visits, 3 percent on clinics, and 29 percent on administration including education.

The 1992–93 Workload Survey, not yet published, is reported as confirming the increased workload, the average general practitioner now spending 65 hours a week on medical services. Workload has increased by 17 percent since 1985 and by 9 percent since 1989.[16]

Surprisingly little interest has been shown in the concept of fund-holding by patients,[17] but this lack of interest is perhaps not too surprising, as only about 2 percent per annum of the patients in an average practice are involved in a planned hospital referral.

Education

To improve services for their patients, many budget holders have developed practice-based consultant (i.e., hospital specialist) clinics. That and the imposed contractual requirement that certain defined patients should be seen by a consultant rather than by a member of the junior hospital staff have led to concern about the impact of the changes on the education of junior doctors. It is too early to say whether this fear is justified, and it will be difficult to measure the effect of the changes as teaching is increasingly taking place in the community in any case.

The Future

Despite the concerns raised by the British Medical Association and the British Labour Party, there seems little doubt that most of the changes of the past few years are unlikely to be reversed. There are some worrying trends, e.g., the number of after hours visits has increased threefold in the past few years — itself a cause of stress to general practitioners and resulting in proposals to develop emergency care centers.[18] There are also concerns about escalating prescribing costs and a fear that general practitioners will consume an undue proportion of the available resources. Some evidence has been produced that patients of nonfund-holding practices are being disadvantaged.[19] There is increasing demand for hospital beds, causing widespread problems with surgical waiting lists. These problems are particularly severe in London and other large cities, where in the past there has been an overconcentration of expensive hospital beds, and there are moves to close and merge some hospitals.[20] Despite these concerns, some of which are not unique to the United Kingdom, there seems little doubt that the developments of the past few years are achieving the objectives set by the UK Government, which is clearly determined to continue with these changes. Proposals have been published recently for further decentralizing the National Health Service[21] at the same time strengthening the purchasing arrangements by merging District Health Authorities (hospital and some community services) with Family Health Service Authorities. General practice is well placed to benefit from these changes, and hopefully it will respond in a positive way to the challenges that are yet to come.

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